STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155104	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CENTER	1201 W BUENA VISTA RD EVANSVILLE, IN47710

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 10, 11, 12, 15, 16, 17, 18, 19, 2011 Facility number: 000043 Provider number: 155104 AIM number: 100290960 Survey team: Amy Wininger, RN TC Diane Hancock, RN (August 10, 11, 12, 15, 16, 18, 19, 2011) Census bed type: SNF: 19 SNF/NF: 114 Total: 133 Census payor type: Medicare: 19 Medicaid: 61 Other: 53 Total: 133 Sample: 24 Supplemental sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	This Plan of Correction for Survey Event OTH711 is submitted under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Furthermore, we request this 2567 (Plan of Correction) serve as our credible allegation of compliance. Listed below are the actions we implemented to comply with Survey Event ID OTH711 for correction of: F TAG 221 SS=D RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS, F TAG 225 SS-D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS, F TAG 226 SS-D DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES, F TAG 282 SS=D SERVICES BY QUALIFIED PERSONS/PER CARE PLAN, F TAG 322 SS=D NG TREATMENT/SERVICES-RESTORE EATING SKILLS, F TAG 364 SS=D NUTRITIVE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 8/25/11 by Jennie Bartelt, RN.		VALUE/APPEAR, PALATABLE/PREFER TEMP, F TAG 431 SS=D DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS, F TAG 441 SS=D INFECTION CONTROL, PREVENT SPREAD, LINENS To complete our plan of correction process we have provided comprehensive in-servicing to all staff, modified appropriate forms, and created new forms to address this survey event.	
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to ensure 2 of 3 sampled residents reviewed for restraints, in the sample of 24, were free of restraints, in that staff were using an abduction cushion to keep a resident from getting up from bed, and a restraint was not released according to the care plan. (Resident #93, #17) Findings include: 1. The clinical record of Resident #93 was reviewed on 08/11/11 at 8:40 A.M. The record indicated Resident #93 had experienced a hip fracture on 02/05/10. The record further indicated the diagnoses of Resident #93 included, but were not limited to, "mental disorder, urinary tract	F0221	F 221 - Immediate Action – On 8/23/11 Resident #93 was assessed for appropriateness of abductor pillow for use as a restraint. A pre-restraining assessment initiated, order obtained from physician, care plan and treatment record updated. F 221 – Review of Residents - on 08/23/11 MDS conducted an audit of all residents with restraints. No residents were adversely affected by this action as it relates to restraint usage. F 221 - On Going Corrective Action - by 9/18 /2011 we will in-service nursing staff on pre-restraining assessment, restraint usage policy and procedure, physical restraint elimination assessment, physical restraint use (care plan # 18) and restraint reduction/elimination	09/18/2011

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	infection, aphasia, arthropathy [joint deterioration], esophageal reflux." The most recent physician's order recap, signed by the physician on 6/11/11, lacked an order for an abductor cushion. The most recent Nursing Monthly Summary, dated 08/03/11, indicated, "22. Restraints NA [not applicable]." The most recent Pre-Restraining Assessment, dated 02/10/10, indicated Resident #93 was assessed, at that time, for 1/2 siderails to aid mobility. The assessment lacked any documentation that Resident #93 had been assessed for the use of a abductor cushion as a restraint. The most current plan of care included an identified problem of "altered skin integrity," dated 02/10/10. The plan of care included an approach of "Turn and reposition...Abductor pillow as requested by family prn [as needed]." The most recent annual MDS [Minimum Data Set] Assessment, dated 01/10/11, and the most recent quarterly MDS, dated 07/11/11, indicated Resident #93 was not using restraints. Resident #93 was observed, on 08/10/11 at 2:45 P.M., to be lying in bed with a hip		protocol. F 221 - On Going Monitoring - the MDS team will initiate the review of residents with restraints quarterly to assure the restraint is appropriate. The findings from MDS will be shared with Interdisciplinary team for review at the weekly falls prevention meeting. Restraint reduction will be attempted at this time, when applicable, to ensure the least restrictive restraint is being utilized.	

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	abductor cushion between her thighs and secured with velcro straps. On 08/11/11 at 3:40 P.M., Resident #93 was observed to be lying in bed with a hip abductor cushion between her thighs and secured with velcro straps. During an interview with CNA #1, on 08/12/11 at 9:40 A.M., she indicated, "[Resident #93] uses the wedge in bed so she doesn't get up. If I don't put in between her legs and secure it, she will get right out of bed." During an interview with LPN #2, on 08/12/11 at 9:45 A.M., she indicated, "[Resident #93] sits straight up in bed if you don't use it. [abductor]" On 08/12/11 at 1:45 P.M., Resident #93 was observed to be lying in bed with a hip abductor cushion between her thighs and secured with velcro straps. On 08/15/11 at 2:00 P.M., Resident #93 was observed to be lying in bed with a hip abductor cushion between her thighs and secured with velcro straps. During an interview with CNA #5, on 08/15/11 at 5:00 P.M., she indicated, "That pillow [pointing to the abductor cushion] is to put between [Resident #93]			

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	legs, so she can't get up." During an interview with the DoN [Director of Nursing], on 08/17/11 at 12:30 P.M., she indicated, "There is no documentation of a restraint for [Resident #93]. I questioned why [Resident #93] was still using an abductor cushion so long after her surgery, I did not know they were using it as a restraint...We did not assess it as a restraint." 2. During the initial tour, on 08/10/11 at 11:00 A.M., LPN #3 indicated Resident #17 used a seatbelt restraint, which was released at meal times. The clinical record of Resident #17 was reviewed on 08/12/11 at 12:45 P.M. An updated care plan for Physical Restraint Use indicated, "Goals/Outcomes: 3/18/11 Use attached belt on resident w/c [wheelchair] as a restraint. Release at meals during supervision." On 08/10/11 at 12:40 P.M., Resident #17 was observed sitting in the dining room being assisted with lunch by CNA #10. A restraint was observed to be intact across his lap. On 08/15/11 at 12:30 P.M., Resident #17			

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was observed sitting in the dining room eating lunch. A restraint was observed to be intact across his lap.

During an interview at that time, QMA #1 indicated, "Oh, his belt is on." QMA #1 was then observed to remove the restraint.

On 08/15/11 at 5:30 P.M., Resident #17 was observed sitting in the dining room being assisted with supper by RN #2. A restraint was observed to be intact across his lap.

3. The policy and procedure for Restraint Usage was provided by the DoN [Director of Nursing], on 08/17/11 at 1:20 P.M., and indicated, "physical...restraints may be utilized only to assist the resident to reach the highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience, and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints."

"Medical symptoms that warrant the use of restraints shall be reflected in the comprehensive assessment and care plan."

"For residents whose care plans indicate the need for restraints, the facility shall plan and implement a systematic, gradual

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	process toward reducing the use of restraints." "Informed consent must be obtained prior to the use of a restraint." "The legal representative cannot give permission to use restraints for the sake of discipline, staff convenience or when the restrain is not necessary to the the resident's medical symptoms. The facility cannot use restraint solely because the legal representative has approved or requested the use of a restraint." "A physician order is required prior to the application of a restraint except in the case of an emergency for 12 hours...Orthotic body devices may be solely for therapeutic purposes to improve overall functional capacity of the resident." "All residents are pre-assessed prior to obtaining an initial restraint order, which can only be ordered by a physician based on a medical need... Definitions: Physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached to or adjacent to the resident body that the resident can not remove easily which restricts freedom of			

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	movement or normal access to one's body....Convenience is defined as any action take by the facility to control resident behavior or maintain resident with a lesser amount of effort by the facility and not in the best interest of the resident...Equipment: 1. Pre-restraint assessment form 2. Quarterly reassessment form 3. Care Plan 4. Type of restraint required 5. Alternative flow sheet..." "Procedure:...9. The restraint is released at least every two hours to allow the resident to ambulate, change position, or use the restroom... Restraint Re-evaluation 1. The compliance nurse or designee will complete the Resident Re-evaluation form within one (1) month of initial use of restraint. The continuing need for restraints is evaluated by the compliance nurse or designee (with input from all three shifts), and revisions tin the plan of care will be made as necessary...5. When the resident is a candidate for restraint release, indicate plan and approached on the care plan. Explain discontinuance to resident, family and or legal representative." 3.1-3(w) 3.1-26(o)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on observation, record review and interview, the facility failed to ensure allegations of abuse were thoroughly investigated and the residents were protected during the investigation, for 3 of	F0225	F 225 - Immediate Action - Memo dated 8/12/2011 ISDH Exit Review was distributed to all management staff. The Alleged Employee to Resident Abuse Checklist was updated to include: # 8 Complete I/A	09/18/2011

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	3 residents reviewed related to four allegations of abuse, from a sample of 24 residents, in that one allegation was not investigated, other residents were not interviewed as part of the investigations, and in one case, staff members were taken into a resident's room for the resident to identify face to face. (Residents #62, #38, #21) Findings include: 1. On 8/12/11 at 3:00 p.m., an allegation of abuse investigation was reviewed. The allegation was made by Resident #62. An Investigative Incident Report, dated 3/3/11 and completed by the Evening Shift Supervisor, indicated the following: "Called to room at 1830 [6:30 p.m.]. Res. reported that older grey hair staff member hit [upper] chest [with] end of call light [and] (R) [right] index finger nail. Cannot recall time or day. All 3-11 female staff taken to room. Shook head no wasn't them. Thought she could identify her if saw her...no new orders left message for DON [Director of Nurses] to call. No redness no bruising...just stated wouldn't take her to bathroom, she would have to wait." "Took [four staff member's names] in room this noc [night] denied any of them." The "Final Report" regarding the		report, Interview resident, if resident unable to provide name of staff member, take photos for resident to review; # 9 Interview 2-3 other residents who have received care from staff member that has been accused. Document interview. F 225 – Review of Residents - No residents were adversely affected by this action as it relates to alleged abuse investigation. F 225 - On Going Corrective Action - By 9/18 /2011 All staff will be in serviced on the revised **Alleged Employee to Resident Abuse Checklist**. F 225 - On Going Monitoring - When a resident alleges abuse from any employee the revised **Alleged Employee to Resident Abuse Checklist** will be completed. The DON/ADON/DESIGNEE will review each completed form to ensure 2-3 appropriate residents have been interviewed, and photos were given for resident to review (if applicable).	

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	investigation included, but was not limited to, the following: The resident's daughter later talked to her mother and the resident recalled a name of the nurse, "[name of nurse]," and indicated it had happened in the last 4 days. Preventative Measures Taken "Will interview staff on other shifts. After receiving further information from the resident...[name of night shift supervisor] took nurse matching the description and whose name was [name of nurse] in resident's room. [The night shift supervisor] asked resident if this was the staff member who hit you with the call light, [name of nurse]. Shook her head no. [The night shift supervisor] asked resident a total of 3 times and after each time resident shook her head no." Results of Investigation "A statement was obtained from nurse [name of nurse]. [Name of nurse] assists resident to her recliner on a routine basis. Resident prefers to sleep in recliner instead of bed. [Nurse] is one of her primary nurses. [Nurse] states that she always clips the call light to resident's gown and does not believe that she has ever struck residents chest or finger. MDS [Minimum Data Set assessment] Cognitive Pattern - resident is rarely/never understood. Has short-term Memory			

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	problem. Has long-term memory problem. Cognitive skills for daily decision making are moderately impaired. Signs and Symptoms of Delirium - altered level of consciousness. There has been no sign of injury/bruising. [Name of nurse] does provide care to this resident on a routine basis. There is no evidence of abuse." On 8/12/11 at 3:30 p.m., the Administrator and Director of Nurses [DoN] were interviewed. The DoN indicated, "Yes, we did take staff into the resident's room," to see if she could identify who hit her with the call light. "No, we did not interview other residents." 2. On 8/12/11 at 3:00 p.m., an investigation of an allegation of mistreatment/verbal abuse, made by Resident #62, was reviewed. Resident #62 had reported to the Unit Supervisor, on 4/27/11 at 8:00 a.m., CNA #2 had told her, "[the resident] had sh-- in her pants and she's not the only one who sh--- around here." The CNA was sent home. Statements were obtained from CNA #2, and CNA #3, who worked with CNA #2 that night. No other staff were interviewed, and no other residents were questioned regarding			

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	mistreatment/verbal abuse. Nurses' notes, included in the investigation documentation, indicated the following: 4/27/11 8:00 a.m. "...tearful reports to this nurse she was mistreated last noc by blonde girl [with] a ponytail - voices that this girl told her she had "shi--her pants et [and] she's not the only one who shi---around here." Resident told nurse she cried most of the noc about how she was treated. Met [with] nurse on duty who says one CNA came to her during noc et told her resident needed a pain pill for her hips which she administered. CNA reports resident was difficult to assist her on BSC [bedside commode] that resident would not place weight on her feet ii [two] CNAs were assiting her..." 4/27/11 8:30 a.m. "Spoke again [with] resident [with] [social worker's name] et myself - Resident seems reluctant @ times to speak. did say a girl [with] blonde ponytail had mistreated her et that this wasn't the 1st time. We asked [resident] if she could possibly indentify the staff member et she said 'yes but I wouldn't want to.' ...SS [social services] asked resident if she might could identify staff through a picture et resident thinks she can..." 4/27/11 12:30 p.m. "Investigation re: alleged abuse now completed."			

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	CNA #2's statement included, but was not limited to, the following: "...[Resident] put on her call light. We do her as a 2 assist because she doesn't stand that well sometimes. Me and [CNA #3] went in there, asked what she needed she said I need to go to the toilet...[CNA #3] and I put her on the bedside commode and she did not void...Nothing was said between the two of us besides the normal greetings and good night [resident]. I do know about a month or so ago, she had reported abuse towards another aid on day shift. I'm not trying to discredit her by any means. She is probably treated a million times better by our staff then most residents receive. I would have never said that to her or even thought of saying that to any of our residents." CNA #3's statement indicated she and CNA #2 had assisted the resident to the toilet; the resident did not void nor did she have a bowel movement. The resident complained of leg and hip pain and wanted a Tylenol. "[Resident] was already upset before I went in there. She was already crying when I went in her room. But I couldn't get her to tell me anything except she was in pain." Social Service notes, dated 4/27/11 [no time], indicated the following: Spoke with [resident] re: incident. [Resident]			

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	155104	A. BUILDING 00 B. WING	08/19/2011

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	was able to identify the employee [and] recall the event. [Resident] did calm [and] was reassured that I would follow up [and] everything would be taken care of..." 4/27/11 [no time] "Issue has been resolved." 4/29/11 [no time] "[Resident] has [no] recall of incident that occurred on 4/27/11." The following "Results of Investigation" were documented: "Diagnoses are Senile Dementia, Alzheimers, and Depression. Residents MDS [Minimum Data Set assessment] Cognitive Pattern - resident is rarely/never understood. Has a short-term and long-term memory problem. Ccognitive skills for daily decision making are moderately impaired. Signs and Symptoms of Delirium - altered level of consciousness. Resident was interviewed by Social Services and has no recall of alleged incident. Resident has previously alleged abuse from another staff member that was unsubstantiated. Staff member, [CNA #2], denies making the statement. There is no evidence of abuse, however, we did suspend [CNA #2] for 4 days until investigation was completed and statements obtained. She will also receive further education on abuse. CNA was moved from Alzheimers Unit to Rehab			

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	Unit. CNA will also receive follow up counseling from [name of psychologist]." The investigation failed to include interviews of other residents this CNA was caring for. The Administrator and Director of Nurses [DoN] were interviewed on 8/12/11 at 3:30 p.m. The DoN indicated they had not interviewed other residents regarding any mistreatment. 3. On 8/12/11 at 3:00 p.m., an investigation of an allegation of physical abuse, made by Resident #38. Resident #38 alleged to CNA #5 that CNA #6 had hurt her. Nurse's notes, included in the investigative documents, indicated the following: 1/27/11 8:30 a.m., "[Name of CNA #5] CNA reported to me that resident is complaining of CNA [Name of CNA #6] hurting her. She said that she grabbed her right arm and squeezed tight. She said to let go of her arm and she didn't let go right away. Resident said that there was another CNA [with] [Name of CNA #6], she doesn't know her name. Resident said [CNA] was trying to get her out of bed...Res. said that when she grabbed her, she said 'ouch your (sic) hurting me.' I told resident that I will investigate the matter..."			

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Social Service Notes, dated 1/27/11 [no time], indicated the following:
"...Resident states that last night, as well as a couple of other times, [CNA #6] hurt her by grabbing her arm and trying to transfer her. [Resident] states that she told her 'let me go! That hurts.' [and] 'stop yanking me around.'

Statements were reviewed. CNA #5's statement, dated 1/27/11, indicated, "All I heard was that [CNA #6] was rough transferring [Resident] from her bed to the toilet...asked her if she would like to speak to a nurse. She said yes. So I spoke to [a nurse] about it."

CNA #6's statement, dated 1/27/11, indicated, "Myself and another CNA attempted to transfer [Resident] to the bedside commode. I grabbed [Resident's] ankles the other CNA grabbed her shoulders and as we turned [the resident], she said ouch d--- it. The both of us asked what's wrong." She indicated the two CNAs decided to leave the resident in bed and pulled her to the head of the bed.

The facility's documented "Final Report" included, but was not limited to, the following:
The resident complained to CNA #5, CNA #5 and CNA #6 wrote out statements.

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	CNA #6 reported that "she did 'grab' resident's ankles while another CNA 'grabbed' her shoulders. She reports that resident did state 'ouch, damn it...'" The CNA was sent home pending investigation. The Results of Investigation indicated, "After reviewing the statements from resident, social service and staff members the determination has been made to provide CNA with additional training. She will receive further guidance on Communication, Residents Rights and Transfers. Following completion of this training CNA will be placed on probationary period of 30 days." There was no indication other residents were interviewed as part of the investigation. The Administrator and Director of Nursing [DoN] were interviewed, on 8/12/11 at 3:30 p.m. The DoN indicated, no they did not include interviews of other residents regarding their care. 4. During initial tour, on 08/10/11 at 12:00 P.M., Resident #21 was observed sitting in her wheelchair in her room. At that time, LPN #3 indicated Resident #21 was not interviewable.			

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	The clinical record of Resident #21 was reviewed on 08/12/11 at 1:30 P.M. The record indicated the current diagnoses included, but were not limited to, Arthritis, and hyperlipidemia. The Nursing notes, dated 05/14/11, indicated, "...often noted to make false accusations of MD [physician] punching her in abdomen and grabbing her breast..." The Nursing notes, dated 05/15/11 at 2:00 P.M. indicated, "...Continues with periods of increased confusion and false accusations..." The Nursing notes, dated 05/18/11 at 8:00 P.M., indicated, "...When staff approaches resident she calls them names and accuses them of being mean to her..." The Nursing notes, dated 06/03/11 at 9:00 A.M., indicated, "...The start [sic] yelling about staff mistreating her for no reasin [sic] at all..." The most recent MDS [Minimum Data Set] assessment, dated 05/18/11, indicated Resident #21 had moderate cognitive impairment. The most recent care plan, dated 05/12/11, for Behavior Intervention, lacked any documentation that Resident #21 made			

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	false accusations of physical abuse. In an interview with the HFA [Health Facility Administrator], on 08/17/11 at 2:00 P.M., she indicated there had been no investigation started because the resident was confused and had behaviors. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interview, the facility failed to ensure their policy was followed for abuse allegations, to include allegations of abuse being thoroughly investigated and residents protected during the investigations, for 3 of 3 residents reviewed related to four allegations of abuse, from a sample of 24 residents, in that allegations from one resident were not investigated, other residents were not interviewed as part of the investigations, and in one case, the staff brought staff	F0226	F 226 - Immediate Action - Upon notification from ISDH resident # 21 was interviewed by Fran Hazel SS on 8/19/2011. F 226 – Review of Residents - No residents were adversely affected by this action as it relates to interviewing/follow up on allegations of abuse. F 226 - On Going Corrective Action - by 9/18/2011 All staff will be in serviced on the **Abuse Prohibition Policy & Procedure** and understands it is the staff's	09/18/2011

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	members into a resident's room for the resident to identify face to face. (Residents #62, #38, #21) Findings include: 1. On 8/12/11 at 3:00 p.m., an allegation of abuse investigation was reviewed. The allegation was made by Resident #62. An Investigative Incident Report, dated 3/3/11 and completed by the Evening Shift Supervisor, indicated the following: "Called to room at 1830 [6:30 p.m.]. Res. reported that older grey hair staff member hit [upper] chest [with] end of call light [and] (R) [right] index finger nail. Cannot recall time or day. All 3-11 female staff taken to room. Shook head no wasn't them. Thought she could identify her if saw her..." "...no new orders left message for DON [Director of Nurses] to call. No redness no bruising...just stated wouldn't take her to bathroom, she would have to wait." "Took [four staff member's names] in room this noc denied any of them." The "Final Report" regarding the investigation included, but was not limited to, the following: The resident's daughter later talked to her mother and the resident recalled a name of the nurse, "[name of nurse]," and indicated it had happened in the last 4		responsibility **to ensure that all allegations of abuse are investigated fully for possible substantiation.** Administrative Nursing staff will be in-serviced on revised A List which includes "any allegations of abuse made by resident? If yes alleged employee to resident abuse checklist completed appropriately". All staff will be in serviced on **Residents Rights**. F 226 - On Going Monitoring - Staff will immediately report any allegation of abuse made by resident to immediate supervisor/designee. To ensure that all allegations of abuse are reported, supervisors will utilize the revised A List form. All alleged allegations will be followed up with investigations and report to ISDH and appropriate agencies by DON/ADON/Designee.	

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	days. Preventative Measures Taken "Will interview staff on other shifts. After receiving further information from the resident...[name of night shift supervisor] took nurse matching the description and whose name was [name of nurse] in resident's room. [The night shift supervisor] asked resident if this was the staff member who hit you with the call light, [name of nurse]. Shook her head no. [The night shift supervisor] asked resident a total of 3 times and after each time resident shook her head no." Results of Investigation "A statement was obtained from nurse [name of nurse]. [Name of nurse] assists resident to her recliner on a routine basis. Resident prefers to sleep in recliner instead of bed. [Nurse] is one of her primary nurses. [Nurse] states that she always clips the call light to resident's gown and does not believe that she has ever struck residents chest or finger. MDS [Minimum Data Set assessment] Cognitive Pattern - resident is rarely/never understood. Has short-term Memory problem. Has long-term memory problem. Cognitive skills for daily decision making are moderately impaired. Signs and Symptoms of Delirium - altered level of consciousness. There has been no			

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	sign of injury/bruising. [Name of nurse] does provide care to this resident on a routine basis. There is no evidence of abuse." On 8/12/11 at 3:30 p.m., the Administrator and Director of Nurses [DoN] were interviewed. The DoN indicated, "yes, we did take staff into the resident's room," to see if she could identify who hit her with the call light. "No, we did not interview other residents." 2. On 8/12/11 at 3:00 p.m., an investigation of an allegation of mistreatment/verbal abuse, made by Resident #62, was reviewed. Resident #62 had reported to the Unit Supervisor, on 4/27/11 at 8:00 a.m., CNA #2 had told her, "[the resident] had sh-- in her pants and she's not the only one who sh--- around here." The CNA was sent home. Statements were obtained from CNA #2, and CNA #3, who worked with CNA #2 that night. No other staff were interviewed, and no other residents were questioned regarding mistreatment/verbal abuse. Nurses' notes, included in the investigation documentation, indicated the following: 4/27/11 8:00 a.m. "...tearful			

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	reports to this nurse she was mistreated last noc by blonde girl [with] a ponytail - voices that this girl told her she had "shi--her pants et [and] she's not the only one who shi---around here." Resident told nurse she cried most of the noc about how she was treated. Met [with] nurse on duty who says one CNA came to her during noc et told her resident needed a pain pill for her hips which she administered. CNA reports resident was difficult to assist her on BSC [bedside commode] that resident would not place weight on her feet ii [two] CNAs were assiting her..." 4/27/11 8:30 a.m. "Spoke again [with] resident [with] [social worker's name] et myself - Resident seems reluctant @ times to speak. did say a girl [with] blonde ponytail had mistreated her et that this wasn't the 1st time. We asked [resident] if she could possibly indentify the staff member et she said 'yes but I wouldn't want to.' ...SS [social services] asked resident if she might could identify staff through a picture et resident thinks she can..." 4/27/11 12:30 p.m. "Investigation re: alleged abuse now completed." CNA #2's statement included, but was not limited to, the following: "...[Resident] put on her call light. We do her as a 2 assist because she doesn't stand that well sometimes. Me and [CNA #3]			

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	went in there, asked what she needed she said I need to go to the toilet...[CNA #3] and I put her on the bedside commode and she did not void...Nothing was said between the two of us besides the normal greetings and good night [resident]. I do know about a month or so ago, she had reported abuse towards another aid on day shift. I'm not trying to discredit her by any means. She is probably treated a million times better by our staff then most residents receive. I would have never said that to her or even thought of saying that to any of our residents." CNA #3's statement indicated she and CNA #2 had assisted the resident to the toilet; the resident did not void nor did she have a bowel movement. The resident complained of leg and hip pain and wanted a Tylenol. "[Resident] was already upset before I went in there. She was already crying when I went in her room. But I couldn't get her to tell me anything except she was in pain." Social Service notes, dated 4/27/11 [no time], indicated the following: Spoke with [resident] re: incident. [Resident] was able to identify the employee [and] recall the event. [Resident] did calm [and] was reassured that I would follow up [and] everything would be taken care of..."			

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	4/27/11 [no time] "Issue has been resolved." 4/29/11 [no time] "[Resident] has [no] recall of incident that occurred on 4/27/11." The following "Results of Investigation" were documented: "Diagnoses are Senile Dementia, Alzheimers, and Depression. Residents MDS [Minimum Data Set assessment] Cognitive Pattern - resident is rarely/never understood. Has a short-term and long-term memory problem. Ccognitive skills for daily decision making are moderately impaired. Signs and Symptoms of Delirium - altered level of consciousness. Resident was interviewed by Social Services and has no recall of alleged incident. Resident has previously alleged abuse from another staff member that was unsubstantiated. Staff member, [CNA #2], denies making the statement. There is no evidence of abuse, however, we did suspend [CNA #2] for 4 days until investigation was completed and statements obtained. She will also receive further education on abuse. CNA was moved from Alzheimers Unit to Rehab Unit. CNA will also receive follow up counseling from [name of psychologist]." The investigation failed to include interviews of other residents this CNA			

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	was caring for. The Administrator and Director of Nurses [DoN] were interviewed on 8/12/11 at 3:30 p.m. The DoN indicated they had not interviewed other residents regarding any mistreatment. 3. On 8/12/11 at 3:00 p.m., an investigation of an allegation of physical abuse, made by Resident #38. Resident #38 alleged to CNA #5 that CNA #6 had hurt her. Nurse's notes, included in the investigative documents, indicated the following: 1/27/11 8:30 a.m., "[Name of CNA #5] CNA reported to me that resident is complaining of CNA [Name of CNA #6] hurting her. She said that she grabbed her right arm and squeezed tight. She said to let go of her arm and she didn't let go right away. Resident said that there was another CNA [with] [Name of CNA #6], she doesn't know her name. Resident said [CNA] was trying to get her out of bed...Res. said that when she grabbed her, she said 'ouch your (sic) hurting me.' I told resident that I will investigate the matter..." Social Service Notes, dated 1/27/11 [no time], indicated the following: "...Resident states that last night, as well as a couple of other times, [CNA #6] hurt			

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	her by grabbing her arm and trying to transfer her. [Resident] states that she told her 'let me go! That hurts.' [and] 'stop yanking me around.' Statements were reviewed. CNA #5's statement, dated 1/27/11, indicated, "All I heard was that [CNA #6] was rough transferring [Resident] from her bed to the toilet...asked her if she would like to speak to a nurse. She said yes. So I spoke to [a nurse] about it." CNA #6's statement, dated 1/27/11, indicated, "Myself and another CNA attempted to transfer [Resident] to the bedside commode. I grabbed [Resident's] ankles the other CNA grabbed her shoulders and as we turned [the resident], she said ouch d--- it. The both of us asked what's wrong." She indicated the two CNAs decided to leave the resident in bed and pulled her to the head of the bed. The facility's documented "Final Report" included, but was not limited to, the following: The resident complained to CNA #5, CNA #5 and CNA #6 wrote out statements. CNA #6 reported that "she did 'grab' resident's ankles while another CNA 'grabbed' her shoulders. She reports that resident did state 'ouch, damn it...'"			

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	The CNA was sent home pending investigation. The Results of Investigation indicated, "After reviewing the statements from resident, social service and staff members the determination has been made to provide CNA with additional training. She will receive further guidance on Communication, Residents Rights and Transfers. Following completion of this training CNA will be placed on probationary period of 30 days." There was no indication other residents were interviewed as part of the investigation. The Administrator and Director of Nursing [DoN] were interviewed, on 8/12/11 at 3:30 p.m. The DoN indicated, no they did not include interviews of other residents regarding their care. 4. During initial tour, on 08/10/11 at 12:00 P.M., Resident #21 was observed sitting in her wheelchair in her room. At that time, LPN #3 indicated Resident #21 was not interviewable. The clinical record of Resident #21 was reviewed on 08/12/11 at 1:30 P.M. The record indicated the current diagnoses			

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	included, but were not limited to, Arthritis, and hyperlipidemia. The Nursing notes, dated 05/14/11, indicated, "...often noted to make false accusations of MD [physician] punching her in abdomen and grabbing her breast..." The Nursing notes, dated 05/15/11 at 2:00 P.M. indicated, "...Continues with periods of increased confusion and false accusations..." The Nursing notes, dated 05/18/11 at 8:00 P.M., indicated, "...When staff approaches resident she calls them names and accuses them of being mean to her..." The Nursing notes, dated 06/03/11 at 9:00 A.M., indicated, "...The start [sic] yelling about staff mistreating her for no reasin [sic] at all..." The most recent MDS [Minimum Data Set] assessment, dated 05/18/11, indicated Resident #21 had moderate cognitive impairment. The most recent care plan, dated 05/12/11, for Behavior Intervention, lacked any documentation that Resident #21 made false accusations of physical abuse. In an interview with the HFA [Health			

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	Facility Administrator], on 08/17/11 at 2:00 P.M., she indicated there had been no investigation started because the resident was confused and had behaviors. 5. The policy and procedure for Abuse Prohibition, dated 3/23/05 and revised 5/28/10, was provided by the Director of Nurses on 8/10/11 at 3:15 p.m. The policy indicated, "Allegations/suspicions/reports of abuse will be investigated immediately to ensure the safety and well being of the resident." The purpose of the policy indicated the following: "To ensure that all allegations of abuse are investigated fully for possible substantiation. To ensure that no staff member that has been accused of abuse has unjust action taken against them." 3.1-28(a)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview the facility failed to ensure that a resident with a restraint was released from the restraint according to the plan of care, in that Resident #17 was observed to be restrained at 3 meals while staff were sitting next to him. The deficient practice affected 1 of 3 residents reviewed related to plan of care for restraints in a sample of 24. Finding includes: During the initial tour, on 08/10/11 at 11:00 A.M., LPN #3 indicated Resident #17 used a seatbelt restraint, which was released at meal times. The clinical record of Resident #17 was reviewed on 08/12/11 at 12:45 P.M. An updated care plan for Physical Restraint Use indicated, "Goals/Outcomes: 3/18/11 Use attached belt on resident w/c [wheelchair] as a restraint. Release at meals during supervision." On 08/10/11 at 12:40 P.M., Resident #17	F0282	F 282 - Immediate Action – Memo dated 8/16/2011, ISDH Exit Review, was distributed to all management staff. Upon notification from ISDH the Administrative Team monitored Dining areas to ensure restraints were released per care plans. F 282 – Review of Residents - No residents were adversely affected by this action as it relates to staff not following care plans. F 282 - On Going Corrective Action - An Administrative Dining Checklist was created as a guide to Administrative Staff for monitoring residents with restraints. All nursing staff, dining assistants, social service and activities staff are to be in serviced by 9/18/2011 on Restraint Care Plans and the 4 Stages of Restraint Reduction. F 282 - On Going Monitoring - Administrative Staff will be scheduled to monitor residents with restraints to ensure restraints are released per care plans utilizing the Administrative Dining Checklist.	09/18/2011

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	was observed sitting in the dining room being assisted with lunch by CNA #10. A restraint was observed to be intact across his lap. On 08/15/11 at 12:30 P.M., Resident #17 was observed sitting in the dining room eating lunch. A restraint was observed to be intact across his lap. During an interview at that time, QMA #1 indicated, "Oh, his belt is on." QMA #1 was then observed to remove the restraint. On 08/15/11 at 5:30 P.M., Resident #17 was observed sitting in the dining room being assisted with supper by RN #2. A restraint was observed to be intact across his lap. 3.1-35(g)(2)			

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F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure a resident with a g-tube received medications prepared according to the facility's policy and procedure for gastrostomy tube administration, and received fluids according to the physician's orders, for 1 of 2 residents reviewed for g-tube medication administration, in a supplemental sample of 5, in that excessive fluids were administered with the medications. (Resident #16) Finding includes: During the observation of a medication pass, on 08/16/11 at 10:00 A.M., RN #1 was observed to prepare and administer g-tube medications for Resident #16. The medications observed to be prepared, included: Lisinopril 10 mg (tablet) [cardiac medication] Aspirin 81 mg (tablet) [anti-coagulant] Tab-A-Vite (tablet) [supplement]	F0322	F 322 - Immediate Action - Administrative Team reviewed **Nasogastric/Gastrostomy Tube P&P** and made revisions to policy and procedure on 8/11/2011. F 322 – Review of Residents - No residents were adversely affected by this action as it relates to nasogastric/gastrostomy tube policies. F 322 - On Going Corrective Action – by 9/18/2011 Current nurses/QMA's will be in serviced on the revised **Nasogastric/Gastrostomy Tube P&P.** F 322 - On Going Monitoring – Staff Development Director/Designee will observe a minimum of one nurse or QMA administering medications per tube monthly during med pass utilizing Skills Check Off for the revised Medication Administration via Enteral Tube P&P.	09/18/2011

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	Amlodopine 10 mg (tablet) [cardiac medication] Celexa 20 mg (tablet) [anti-depressant] Colace 50 mg/5 ml (liquid) [stool softener] Tegretol 200 mg (tablet) [seizure medication] Namenda 10 mg (tablet) [Alzheimer's medication] Lorazepam 0.5 mg (tablet) [anti-anxiety medication] Potassium Chloride 8 mg (liquid) [supplement] Neurontin 300 mg (tablet) [pain medication] RN #1 was then observed to flush the g-tube with 30 cc of water. RN #1 was then observed to add 50 cc of water to each medication and administer each medication separately. RN #1 indicated, at that time, "Our policy is 50 cc with each med, so I probably went over by 60 cc. She is supposed to get a 240 cc flush with her meds, so I will give her 180 cc." This resulted in the resident receiving 760 cc of water with the medication administration. The July 2011 Physician's Recap for Resident #16 included, but was not limited to, orders for "250 cc water flush every 4 hours per PEG tube."			

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	The policy and procedure for Medication Administration, provided by the DoN on 08/17/11 at 1:15 P.M., indicated, "Mix the crushed medication with the diluting liquid...pour the liquid medication directly into the diluting liquid...As the last of the medication flows out of the syringe add 30-50 cc of water (or as ordered by the physician)..." The Geriatric Medication Handbook Eighth Edition, page 133 Medication Administration Via Enteral Tubes Procedures: "6. ...a. Crush immediate-release tablets into a fine powder then dissolve in 30 ml of warm water, or prescribed amount. b. Open immediate-release capsules, crush contents into a fine powder and dissolve in 30 ml of warm water, or prescribed amount...d. dilute liquid medications with 10-30 ml of warm water..." In an interview with the DoN [Director of Nursing], on 08/17/11 at 12:30 P.M., she indicated, "for a g-tube, our policy isn't to give 50 cc [of water] with each med. [Resident #16] got too much water." 3.1-44(a)(2)			

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F0364 SS=D	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review and interview, the facility failed to ensure food was served at a palatable temperature, to 1 of 1 sampled resident, in the sample of 24, observed during 1 of 2 meals observed. (evening meal 8/15/11) (Resident #79) Finding includes: On 8/15/11 at 6:00 p.m., Resident #79 was observed seated at a table in the Reflections Unit Activity/Dining area. A dinner tray was observed setting on the table in front of the resident. The food and drinks were covered. At 6:22 p.m., CNA #7 was preparing to feed Resident #79. She uncovered the food and started putting tartar sauce on the fish. No attempt to heat up the food was made. The last tray on the tray cart, which was a tray that had been refused by a resident, was used as a test tray. The temperatures were checked and included the following: Fish, 90 degrees Fahrenheit, tasted cold	F0364	F 364 - Immediate Action - August 15, 2011 after notification from ISDH we immediately reviewed concerns of food service/temperatures (see memo) F 364 – Review of Residents - No residents were adversely affected by this action as it relates to serving food at inappropriate temperature levels. F 364 - On Going Corrective Action – by 9/18/2011 Staff will be in serviced on serving food in timely manner per Meal Service Guidelines. F 364 - On Going Monitoring - Administrative Dining Checklist was created as a guide to assist Administrative Staff to ensure food is served in timely manner.	09/18/2011

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	Cole Slaw, 64 degrees Fahrenheit Mighty Shake, 60 degrees Fahrenheit Milk, in insulated cup, 60 degrees Fahrenheit QMA #1 and CNA #8 indicated, during interview at 6:25 p.m., staff that were out on the hall were getting people back to their rooms from the first meal service, and busy on the hall and had not come to help feed residents. The policy and procedure for Food Temperatures, dated 2/2011, was provided by the Administrator on 8/19/11 at 11:25 a.m. The procedure included, but was not limited to, the following: "Foods should be transported as quickly as possible to maintain temperatures for delivery and service. food should be served at preferable temperature (hot foods are served hot and cold foods are served cold) as discerned by the resident and customary practice." 3.1-21(a)(2)			

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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based observation, interview, and record review, the facility failed to ensure controlled medications were securely locked for prevention of access by unauthorized persons. The medications were oberved in unlocked refrigerators in 2 of 4 medication rooms (Reflections Unit, Hearthside Unit). The deficient	F0431	F 431 - Immediate Action - Lock added to Reflections refrigerator, lock on Hearthside refrigerator locked and maintenance request made to add automatic door closure/lock to door on Hearthside med room. F 431 – Review of Residents - No	09/18/2011

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	practice affected 3 of 3 residents, in a supplmental sample of 5, who had controlled medications stored in the refrigerators on the Reflections and Hearthside units. (Residents #60, #83, #107) Findings include: During an environmental tour, on 08/16/11 at 11:00 A.M., the medication refrigerator in the medication room of the Reflections Unit was observed to not have a lock installed. Upon further observation of the refrigerator contents, at that time, the refrigerator was observed to contain 11 vials of liquid Ativan [anti-anxiety medication] for Resident #83 and 1 bottle of liquid Ativan for Resident #60. During an interview with Unit Director #1, on 8/17/11 at 9:40 A.M., she indicated, "Refrigerated narcotics should be double locked." During an environmental tour, on 08/17/11 at 11:15 A.M., the medication room door of the Hearthside Unit was observed to be propped open. CNA [Certified Nursing Assistant] #1 was observed to be sitting at the desk eating. The medication refrigerator was observed to be unlocked. Upon further observation of the refrigerator contents, at that time,		residents were adversely affected by this action as it relates to narcotics storage. F 431 - On Going Corrective Action – By 9/18/11 all nurses/QMA's will be in serviced on Medication Storage Policy & Procedure. Administrative Nursing staff will be in-serviced on revised A List which includes "Med Room and Narcotic Refrigerator Locked." F 431 - On Going Monitoring - Pharmacy Nurse Consultant/Designee will include "Med Room Locked" under Observations during Med Room Inspection. To ensure narcotics stored in refrigerator are double locked the supervisors will utilize the revised A List form.	

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	the refrigerator was observed to contain 11 vials of liquid Ativan for Resident #107. During an interview, at that time, LPN #2 indicated, "Is that supposed to be locked? We generally don't lock that frig." During an interview with the DoN [Director of Nursing], on 08/17/11 at 11:40 A.M., she indicated, "Refrigerator with narcotics in them should be locked." The policy and procedure for Medication Storage and Security was provided by the HFA [Health Facility Administrator] on 08/18/11 at 1:10 P.M. The policy indicated, "narcotics must [sic] double locked at all times...." 3.1-25(n)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure hands were washed between soiled and clean tasks, and/or bedside equipment was sanitized, for 2 of 2 observations of care	F0441	F 441 - Immediate Action - Upon notification from ISDH Marina Tieken, Director of Personnel Services provided one on one instruction with bathing procedure with CNA #9., including hand	09/18/2011

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	with 1 of 8 sampled residents observed during assistance with personal hygiene, in the sample of 24. (Resident #29) Finding includes: On 8/15/11 at 11:12 a.m., CNA #9 was observed giving Resident #29 a shower. The resident urinated and had a bowel movement during the shower. The CNA was observed to change gloves after contact with the feces, but did not wash her hands between glove changes. On 8/15/11 at 2:45 p.m., CNA #9 was observed to transfer Resident #29 back to bed. The resident had been incontinent of bladder and bowel. The CNA wore gloves and washed, rinsed, and dried the resident. With the same gloves on, she placed a clean incontinence brief, handled the resident to turn from side to side, washed the front perineal area, applied the tabs to the clean brief, handled the resident's clothes and clean linens. She then took her gloves off and used alcohol gel. The wash basin used had been on the overbed table, with some spillage of water. The CNA took a wash cloth, with the soapy water from the basin and washed off the overbed table. There was no sanitizing of the table. She then put up the wash basin and washed her hands.		washing and gloving with return demonstration and correct procedure for sanitizing bedside equipment. F 441 – Review of Residents - No residents were adversely affected by this action as it relates to personal care, bathing, and infection control measures. F 441 - On Going Corrective Action – by 9/18/2011. All nursing staff will be in-serviced on the revised Performance Improvement Bathing procedure (which include the glove and hand washing procedures) and revised equipment cleaning policy & procedure. F 441 - On Going Monitoring – During the orientation process all CNA's will be instructed in the revised bathing procedure (including gloving and hand washing) with return demonstration. A random sampling of 5% of CNA's will be monitored monthly with the Revised Performance Improvement bathing procedure.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA #9 was interviewed, on 8/15/11 at 3:00 p.m. She indicated she knew she had forgotten to change her gloves and wash her hands. She indicated they usually just wiped off the table, that housekeeping did the sanitizing of the tables when they cleaned the room. The policy and procedure for Hand Hygiene, dated 3/06 and revised 8/09, was provided by the Director of Nurses on 8/19/11 at 10:15 a.m. The policy indicated, "Hand hygiene refers to handwashing with soap (anti-microbial) or using alcohol-based hand rubs that does not require access to water." The Policy indicated, "Staff will wash their hands under running water using an antimicrobial agent and water after: 1. Any procedure that requires the use of gloves. 2. Before and after each resident contact as procedure indicates. 3. When moving from a "dirty" site to a "clean" site during procedures such as bathing, toileting and perineal care of a resident (remove gloves, wash hands and proceed with procedure)..." "ALCOHOL-BASED HAND SANITIZER Staff may also use an alcohol-based hand			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155104	A. BUILDING 00 B. WING	08/19/2011

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	sanitizer: 1. When not dealing with any of the areas listed above. 2. When hands are not visibly dirty, or visibly with blood or body fluids." The policy and procedure regarding glove use, dated 5/8/03, was provided by the Director of Nurses on 8/19/11 at 10:15 a.m. It indicated gloves were to be worn when there was a likelihood of hand contact with blood or other potentially infectious materials, mucous membranes, or non-intact skin. The policy indicated: "Hands shall be washed after gloves are removed." "Gloves shall be changed between residents and when moving from a contaminated to a clean body site." 3.1-18(b)(1) 3.1-18(l)			